CHAPTER VI
QUALITY MANAGEMENT REVIEW AND UTILIZATION REVIEW

CHAPTER VI
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Chapter VI
QUALITY MANAGEMENT REVIEW

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456, and may be conducted by DMAS or its designated agent. The Department of Medical Assistance Services (DMAS) conducts periodic quality management reviews (QMRs) on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. This chapter provides information on QMR and Compliance Reviews conducted by DMAS.

GENERAL REQUIREMENTS FOR QUALITY MANAGEMENT REVIEW (QMR AND COMPLIANCE REVIEWS)

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based waivers in the Commonwealth of Virginia and will perform routine QMRs of waiver services and providers.

DMAS or its designated agent will conduct ongoing monitoring of compliance of a provider with DMAS participation standards and policies. A QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, or referral to the Division of Program Integrity for determination of retractions.

DMAS or its designated agent will conduct QMRs of waiver services provided by all providers to ensure the health, safety, and welfare of the individual and the individual's satisfaction with services. The reviews will focus on the Centers for Medicare and Medicaid's (CMS') assurances of individual service plans, including individual preferences, services being delivered in accordance with the Plan for Supports and the identification and inclusion of risks. In order to

monitor the health, safety and welfare of individuals the QMR also includes the review of documents and reports related to incident reporting (i.e. incident reports, APS reports, CPS reports, Department of Behavioral Health and Developmental Services (DBHDS) incident reporting system). In addition to assessing the individual's ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure an individual's satisfaction with services and providers, and that individual choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During QMR and compliance reviews, staff will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. Staff will request registered nurses' (RNs') and other health professionals' licenses, including those of licensed practical nurses (LPNs), Certified Nursing Assistants (CNAs), and others who have provided services. In addition, staff request work references or the documentation of attempts to obtain them, documentation of any required training and/or certification, documentation of criminal background checks, and any other staffing requirements as identified in DMAS and DBHDS regulations and policies. The provider is responsible for ensuring that all staff of the provider agency meets the minimum requirements and qualifications at the start of the employment. For consumer-directed services, the employer of record (EOR) is responsible to ensure that all stated requirements are met in the hiring and employment of attendants providing consumer-directed services.

During reviews, DMAS staff will identify any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS staff may also require additional documentation to verify that the provider agency is in compliance with DMAS provider agreements and policies, including requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services that the provider has a participation agreement to provide.

Providers are continually assessed to ensure they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals in need of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care and who are receiving services through the Developmental Disabilities (DD) Waivers. Information used to make this assessment includes any DMAS desk or on-site reviews of the documentation submitted by the provider, the provider's files, interviews with staff and with individuals and, visits to homes or program locations. DMAS bases its assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following:

- Individuals served by the provider meet the program's eligibility criteria. If DMAS or its designated agent determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver services as set forth in DMAS regulations, DMAS will review and request

that the individual be removed from the waiver and that alternative services be discussed with the individual.

- Services rendered must meet the individual's identified needs, be in accordance with an active plan for supports, and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through observation and communication between the provider, the individual and other provider staff. The plan for supports must be revised in accordance with any substantial change in the individual's status, and the individual's record must contain documentation of any such change. This also includes the provider's responsibility to identify and inform the support coordinator or to obtain any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, etc.).

- Provider documentation must support all services billed to DMAS.

- Document and maintain written semi-annual supervision notes for each Direct Support Professional (DSP) that are signed by the supervisor. Additionally,

- For DBHDS-licensed entities, the provider must provide ongoing supervision of all companions and/or DSP staff consistent with the requirements of 12VAC35-105.

- For providers who are licensed by VDH or have accreditation from a CMS-recognized organization as a personal care or respite care provider, they must provide ongoing supervision of companion or DSP staff consistent with regulatory requirements.

- Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation should be written, signed, and dated on the day the described supports were provided. However, documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual supports delivery is to be noted in the body of the note. In instances when the individual does not communicate through words, the provider must note his observations about the individual's condition and observable responses, if any, at the time of service delivery.

- Examples of unacceptable person-centered progress note written documentation include:

    - Standardized or formulaic notes;
    - Notes copied from previous service dates and simply re-dated;
    - Notes that are not signed and dated by staff who deliver the service, with the date services were rendered; and

- Notes that do not document the individual's unique opinions or observed responses to supports;

- Maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe for services with a unit of service shorter than one day) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based supports, services facilitation, and personal emergency response system support, where initial documentation to support claims will suffice.

- Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of supports is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the provider agency representative who is responsible for the oversight of the plan. Some of the elements included in quality of supports are:

  - Consistency of supports;
  - Continuity of supports;
  - Adherence to the plan for supports; and
  - Consideration for the health, safety, and welfare needs of the individual.

- Providers opting to use an electronic signature for documentation purposes must comply with the following:

  - The electronic signature can be clearly identified
  - The electronic signature identifies the individual signing the document and the date of the signature,
  - The electronic signature cannot be altered once it is attached to a document
  - The date of the signature cannot be altered once attached to the signature
  - Documents cannot be signed electronically by anyone other than the individual required to sign the document, and
  - Documents containing electronic signatures can be printed out upon the request of QMR Analyst.

- The provider will maintain a record for each individual. If more than one service is provided, the record will be divided by service. Forms that may be used are available on the DMAS website at **www.dmas.virginia.gov** or the DBHDS website at **http://www.dbhds.virginia.gov**

DMAS will review the provider's performance in all the outcome areas to determine the provider's ability to achieve high quality supports and conform to DMAS regulations and policies. DMAS is responsible for providing feedback to the provider regarding those areas that may need improvement. During QMR reviews, DMAS will review individual files and conduct site visits to assess the quality of supports and continued appropriateness of services. DMAS will evaluate the individual's status, satisfaction with the service, and appropriateness of the current plan for supports. If the plan for support is found to be inadequate, DMAS will require a revision of the plan to meet the needs of the individual.

DMAS conducts QMRs and compliance reviews to assure that the services provided are appropriate and comply with the policies and procedures for the provision of services under the DD Waivers. For the general requirements, DMAS uses the following procedures:

- DMAS or its designated agent will conduct an on-site review and/or desk review by the provider of each service periodically.

- The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.

- QMRs and compliance reviews may be unannounced.

- Providers may be asked to bring program records to a central location.

- During an on-site QMR or compliance review, staff will review the individual's record in the provider's place of business/offices, paying specific attention to the Plan for Supports, supervisory notes (RN and SF), daily records, support logs or progress notes, screening documentation, and any other documentation that is necessary to determine if services were rendered appropriately. Staff may also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the review of the individual's supports during QMR reviews.

- Upon completion of on-site activities for a QMR, DMAS staff will meet with designated staff to conduct an exit conference, The purpose of the exit conference is for DMAS to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.

- Following the QMR review, a written report of the findings is sent to the provider. During the review process, staff will offer technical assistance and consultation to the

provider regarding DMAS regulations, policies, and procedures or may refer providers to DBHDS staff for more in-depth technical assistance or training. If questions arise regarding compliance issues, staff will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

- If a corrective action plan is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS for approval. At that time, the provider may submit additional documentation for review.

- If there are findings that are related to licensing procedures, a letter stating these findings may be submitted to other agencies, as appropriate (e.g., Department of Health Professions, or DBHDS).

- DMAS will follow up on any corrective action plans that are submitted to ensure that corrective procedures within the plan are implemented by the provider.

- See the Compliance Review Section of this manual for additional information regarding written findings from these types of reviews.

REVIEW OF ID AND DD TARGETED CASE MANAGEMENT AND DD WAIVERS SERVICES

In addition to the general QMR and compliance review requirements, DMAS also reviews for specific requirements for the provision of ID/DD Targeted Case Management and ID & DD Waivers Services. These requirements are: 1) eligibility for services; 2) that the services are based on comprehensive and ongoing assessment and person-centered planning; 3) that services are delivered, reviewed, and modified as appropriate; 4) that the provider is qualified; and 5) that the services are consistent with billing limitations. Specific requirements for each area follow.

Eligibility for ID or DD Case Management Services

- There is basis for initiating DD or ID Targeted Case Management services.

    - There must be documentation of diagnostic eligibility (DD diagnosis for DD Targeted Case Management services and ID diagnosis for ID Targeted Case Management per Code of Virginia § 37.2-100) in the record of an individual receiving DD or ID Targeted Case Management services.

    - There must be documentation that the individual requires and receives active case management services.

- ID or DD Targeted Case Management services must not duplicate any other Medicaid service provided under the Virginia State Plan for Medical Assistance or under any waiver including the DD waivers.

- There is basis for initiating 90-day ID Targeted Case Management.

  - Referral information for an individual to receive 90-day ID Targeted Case Management services must be clearly documented and provide a basis for this service. This includes evidence in the case management record that: a) the individual had not previously received formal case management services; b) the individual did not have diagnostic information necessary to determine eligibility; c) there was reason to suspect the presence of ID; and d) there was an indication of a need for ongoing active case management services.

  - Documentation must indicate that the 90-day Plan for Supports began no earlier than the date of the initial face-to-face contact with the individual and ended when the assessment information (diagnosis and need for active case management) was completed, but no later than 90 days from the start date. Billing can occur for a maximum of three months. If prior to the end of the 90 calendar days, an individual is determined ineligible, appropriate notification of the right to appeal must be sent to the individual.

Eligibility for DD Waivers Services

- The individual meets the diagnostic criteria for DD as described in Chapter IV.

- The individual meets functional eligibility. For individuals receiving DD Waivers services, the ICF/IID level of functioning survey, the Virginia Individual Developmental Disability Eligibility Survey (VIDES infant, child, or adult) must be in the support coordination/case management record, have been completed no more than six months prior to the start of waiver services, and document that the individual meets the dependency level in 2 or more for children and infants and 3 or more for adults. This must be reviewed and completed annually and reflect the current status of the individual.

- There is basis for initiating DD Waivers services.

  - The support coordination/case management record for an individual receiving DD waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above.

- Documentation must be evident that the individual is receiving Targeted Case Management at the time DD waiver services are initiated and during any month in which DD waiver services are provided. A support coordination/case management Plan for Supports must be available in the record.

- For the DD waivers, documentation must indicate that the individual meets the priority one criteria (outlined in Chapter IV) at the time of enrollment.

- The individual continues to meet eligibility for services.

  - It must be clearly documented in the support coordination/case management record that the individual's eligibility and need for continuation of any DD Waivers services is reviewed at least annually.

  - To confirm continued diagnostic eligibility for DD Waivers services, the support coordination/case management record must contain evidence that the individual has a developmental disability. There should be documentation that an updated psychological or other evaluation is completed whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological or other evaluation. The psychological or other evaluation must be completed by a licensed professional with documented training in conducting the evaluation.

  - The support coordination/case management record of individuals receiving DD Waivers services must contain a VIDES that was administered on an annual basis by the support coordinator/case manager. The individual must meet the indicated dependency level in two or more (for infants) or three or more (for children and adults) of the categories on the VIDES. The support coordinator/case manager will indicate on the VIDES what information from the medical record was used in scoring.

- **Comprehensive and Ongoing Assessment and Planning**

  - An Individual Support Plan is completed and reviewed.

- The support coordination/case management record must include an Individual Support Plan that organizes the services and supports that are provided to the individual. The five essential components of an Individual Support Plan include:

  - The Essential Information (including risk assessment)

  - Personal Profile to include the individual's vision for a good life and desired outcomes including risk mitigation;

- Shared planning

- A documentation of agreement signed (may be a signature page) by those participating in the development and implementation of the Individual Support Plan.

- A separate Plan for Supports for each waiver - service requested and received by the individual (including DD and ID Targeted Case Management., which outlines the activities planned to assist in meeting the individual's needs and in attaining the individual's desired outcomes; and

- There must be evidence that the Individual Support Plan is reviewed by the support coordinator/case manager and updated annually (every 12 months) and whenever changes or service modifications occur.

- There is comprehensive and current assessment information.

  - There must be a Personal Profile in the support coordination/case management record, completed by the team, no earlier than one year prior to start date of services and updated annually. The Personal Profile summarizes the individual's vision of a good life, his/her talents and contributions, and "what's working/what's not working" in the following life areas:

    - Home
    - Community and interests
    - Relationships
    - Work and alternates to work
    - Learning and other pursuits
    - Money
    - Transportation and travel
    - Health and safety

  - Additionally, the support coordinator/case manager maintains the Essential Information, updated at least annually and as needed, which includes:

    - Contact information
    - Emergency contacts/representation
    - Psychological or other developmental disabilities diagnostic evaluation
    - Current VIDES Support Coordination and provider contacts
    - Communication and sensory supports
    - Health, medications and physicals

- Summary of social/developmental/behavioral/family history/previous interventions and outcomes
- Summary of employment and educational background
- Active medical and behavioral support needs/risk assessment
- Ability to access services and supports
- Legal, financial, and advocacy issues

- There should be medical information in the support coordination/case management record for any individual receiving DD waivers services. Individuals receiving DD waivers services must have a medical examination completed no earlier than 12 months prior to the start of waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS.

- The support coordination/case management record for an individual receiving DD Waiver services should contain the Virginia SIS™ (completed every fourth year by a contractor) and a risk assessment completed no more than 12 months prior to the start date of waiver services:

    - At least every four years for those individuals who are 22 years of age and older;
    - At least every three years for those individuals who are 16 years of age through 21 years of age; or
    - Every two years for individuals five years through 15 years of age when the individual is using a tiered service.
    - For children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile, will be completed by the appropriate professional every two years for service planning purposes.

- The above assessment information must be provided to the services providers to be available to use to develop their Plans for Supports.

- The individual and others, as appropriate, are involved in the planning process.

    - Documentation must indicate that the individual (or legal guardian, when appropriate) provided consent to exchange information with other agencies. The support coordination/case management record of an individual must contain a signed copy of this form, completed prior to the initiation of the DD Waiver services.

- Documentation must indicate that the individual (or legal guardian, when appropriate) was given the choice between institutional care and DD Waivers services, as appropriate. The support coordination/case management record must contain a copy of the form entitled "Documentation of Individual Choice between Institutional Care or Home- and Community-Based Services" (DMAS 459-C or Virginia Informed Choice DMAS 460/459A). This form is required at the initiation of any waiver services and should be maintained in the individual's support coordination/case management record.

- Documentation must be in the support coordination/case management record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the DD Waivers (this is done on the Individual Choice form (DMAS 459c) or Virginia Informed Choice DMAS 460/459A).

- Documentation must indicate that the individual (or legal guardian, when appropriate) was informed of all DD waivers providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any waiver services, whenever new services were added, when changes occur in providers, or when requests are made by the individual. The individual's record must contain a copy of the form entitled, "Virginia Informed Choice" (DMAS-460/459A).

- Documentation must indicate that the individual (or legal guardian or family) was involved in the development of the Individual Support Plan. The team should meet within 30 calendar days of the waiver enrollment date to discuss the individual's needs, existing supports, and agency-directed and consumer-directed service options for developing the Individual Support Plan. At a minimum, the individual's (and family/caregiver, as appropriate) input and satisfaction with the plan should be documented by signature(s) on the ISP in addition to the support coordinator's/case manager's signature. The individual must sign each provider's plans for support.

- Documentation must indicate that the individual (or legal guardian) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement should accompany any changes to the Individual Support Plan.

- For any termination or decrease of ID or DD Targeted Case Management, DD Waivers services, the support coordination/case management record must contain written notification to the individual of the pending action and the right to appeal. See the appeal section in Chapter II for specific requirements.

- The Support Coordinator/Case Manager receives and reviews each Plan for Supports.

    - Each Plan for Supports must be completed prior to the initiation of services and must designate supports based on current information, reflective of the individual's desires, input, and other assessment information and agreed to by the team.

    - Each Plan for Supports must clearly describe the activities of the individual and staff. There must be a separate document maintained by the provider containing the support instructions that are related to the measurable support activities detailed in the Plan for Supports, as appropriate for the individual and congruent with the type and amount of service units approved through the Waiver Management System (WaMS).

    - Each Plan for Supports must include activities and supports that are meaningful and address the individual's desired outcomes. Each Plan for Supports must satisfy the specific Medicaid criteria and service limitations for each service as described in Chapter IV.

    - The general schedule of supports must be consistent with the service units authorized for that service.

    - When a 60-day assessment period is utilized for any type of residential support, personal assistance (agency-directed), any type of day service, or supported employment services, there must be evidence that the individual is new to the program/provider and a preliminary Plan for Supports and general schedule of supports are included in the record. Documentation must confirm attendance and provide specific information as described in the Plan for Supports support activities. There must be an annual Plan for Supports, based upon the assessment information, developed prior to the last day of the assessment period.

Services are Delivered, Reviewed, and Modified as Needed

- Services occur as planned or are adjusted to accommodate the individual's needs and requests.

    - There must be ongoing documentation in the record of each service provider regarding the services provided to the individual and available for review by the support coordinator/case manager, DBHDS, DMAS, and the individual or family or both, in accordance with applicable policies and regulations. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, results of medical appointments/consults and daily progress notes/support logs.

- The record must document a minimum of one support coordination/case management face-to-face contact with the individual within each 90-calendar day period with a 10-calendar day grace period. There must be evidence that the case manager assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for reimbursement.

- Each service provider's records (including support coordination/case management) must contain documentation that corresponds to the Plan for Supports support activities and indicates that services have been provided according to the plan. While this data may take many forms, it should be appropriate to the individual's supports and demonstrate that his or her desired outcomes are being addressed.

- Services are reviewed at least quarterly.

  - There must be documentation that the support coordinator/case manager reviewed on a quarterly basis all services provided (including Targeted Case Management services). A 30-calendar day grace period to complete the person-centered (quarterly) review of the Individual Support Plan will be permitted. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - There must be evidence that person-centered reviews for the waiver services are completed and sent to the support coordinator/case manager no more than 10 calendar days following the end of each quarter as determined by the effective start date of Individual Support Plan. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - The person-centered review for each service, including support coordination/case management, will be reviewed to determine if it addresses a) the effectiveness of the services; b) any significant events; c) the individual's and, when appropriate, the family's/caregiver's satisfaction with the services and other input; and d) changes in the desired outcomes, support activities or instructions when they are ineffective or upon the individual's request.

- A comprehensive review of each service occurs annually (every 12 months).

  - The support coordination/case management record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery,

and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desired outcomes.

- All providers must be invited to the meeting and participate in the development of the new Individual Support Plan annually (no longer than 365 days – 366 days in a leap year – between Individual Support Plan effective dates). There is no grace period.

Provider Qualifications

There is documentation of the needed license, certification, vendor agreement, or approval.

- It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's staff qualifications.

- Provider qualifications and expectations are outlined in Chapters II and IV of this manual.

Services Delivered are Consistent with Service Limits

- Services must be authorized or preauthorized as appropriate.

  - All DD waivers providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill.

  - DD waivers services require authorization by DBHDS in order for the provider to be eligible for reimbursement. Consumer-directed (CD) services facilitation does not require service authorization. The number of hours does require authorization.

  - Terminations of single waiver services are processed via the WaMS. Terminations of all waiver services must be reflected on a completed DMAS-225.

- There must be documentation that services were provided in accordance with the service plan and as billed.

  - Billing for ID or DD Targeted Case Management services must be supported by a minimum of one direct or individual-related contact, activity, or communication and must be documented each month relevant to the Individual Support Plan during any month for which a claim for ID or DD Targeted Case Management is submitted. Written work and travel time are excluded. Billing for 90-day ID Targeted Case Management may only occur for a maximum of three months.

  - Billing for group day services, community coaching, community engagement, and group supported employment services must be supported by attendance documentation that

verifies individual participation in the service in accordance with the Plan for Supports. The billing should indicate a total number of hours that is equal to or greater than the number of hours billed each day in a month. The documentation must include, at a minimum, the date services were rendered, the number of hours provided, the activities to support the type of service delivered.

- In instances where group day services staff are required to ride with the individual to and from group day service, the group day service staff time may be billed as group day service, provided that the billing for this time does not exceed 25% of the total time the individual spent in the group day service activity for that day. Documentation will be maintained to verify that billing for group day service staff coverage during transportation does not exceed 25% of the total time spent in the group day service for that day.

- Additionally, there must be documentation to support the one (1) staff to one (1) individual ratio required for community coaching, the one (1) staff to three (3) individuals ratio required for community engagement and the one(1) staff to seven (7) individuals ratio required for group day service. There must be documentation to support that no more than 10% of the total number of authorized hours per month is used for planning community activities for community engagement.

- Billing for individual supported employment services, and workplace assistance services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document which shows the date, hours, and type of service rendered, in accordance with the Plan for Supports must be maintained.

- Billing for residential support services:

    - In-home services are billed for actual service hours. Independent living supports is authorized for monthly/partial monthly units. Documentation must include dates, the amount of time, and services that were provided in accordance with the Plan for Supports. When unavoidable circumstances occur such that a provider is at an individual's home at the designated time, but cannot provide services for the entire period scheduled, billing is allowed for the entire number of hours scheduled that day, as long as some portion of the Plan for Supports is implemented. It is expected that this will occur rarely, and there will be detailed documentation of the date, original schedule, time services were actually provided, and specific circumstances which prevented provision of all of the scheduled services. If this occurs on a regular basis over a 90-day period, the support coordinator/case manager should determine the reasons, and a new Plan for Supports with fewer hours or a change in schedule must be developed.

    - Billing for shared living services should be supported by documentation related to the

portion of rent, food, and utilities reasonably attributed to the person who resides with the individual as well as the provision of services noted in agreement

- Group home residential, supported living, and sponsored residential services are billed using a daily rate based on the supports level assignment for each individual. Documentation of support activities provided in accordance with the Plan for Supports will be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled and support the assigned supports level.

- Billing for therapeutic consultation, community-based crisis supports, crisis support services, center-based crisis supports, private duty nursing, skilled nursing, and agency-directed respite, agency-directed personal assistance, or agency-directed companion services must be supported by documentation of the types, dates and the amount of time required for actual service delivery.

- Billing for consumer-directed services is supported by employee time sheets that are signed by the individual (or employer of record) and employee.

- Billing for environmental modifications and assistive technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts.

- Billing for personal emergency response systems (PERS) and Electronic Home-Based Supports (EHBS) must be supported by documentation regarding the installation of and training required to use the required device(s). Monthly billing for the ongoing monitoring services must be supported by documentation of the provision of this monitoring service occurred. In the case of PERS, this takes the form of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken of behalf of the individual.

- Billing for transition services must be supported by item purchase receipts with a description of the item(s) included.

- Billing for Individual and Family Caregiver Training must be supported with documentation to verify the training took place, the individual or family/ caregiver participated in training and what information was taught during the training.

- It is not permissible to automatically bill each month at the maximum amount authorized. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered it may result in disallowance of payment during compliance reviews.

- All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, areas of non-compliance will be cited in the written report of findings. A corrective action plan will be requested if citations result from the quality management review. The following is a non-inclusive list of circumstances that may result in a request for an corrective action plan or may result in denial of payment during compliance reviews:

    - Absence of a current Plan for Supports;

    - Services not delivered as described in the Plan for Supports;

    - Services rendered to an ineligible individual: if diagnostic assessment and/or VIDES do not reflect eligibility for ID or DD Targeted Case Management or DD Waivers;

    - Support coordination/case management face-to-face contacts that are not completed in a timely manner (every 90 days with a 10-day grace period);

    - Any periods of services billed for which there is an absence of or inadequate documentation to support that the services were rendered (amounts, type, absence of data, assessment information, etc.);

    - Any periods of service billed during which the staff were not certified, qualified, or properly trained, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked or converted to a provisional license

    - Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.;

    - There is no documentation reflecting the need for a service or for that level of service; and

    - Absence in the support coordinator's/case manager's record of a current VIDES or the presence of a most recent VIDES that does not meet the requirements for eligibility.

    - The provider must meet all other criteria and documentation requirements found elsewhere in this manual, as well as in applicable regulations and laws.

- If the individual has a patient-pay amount, a provider will use the electronic patient pay process. Local departments of social services (LDSS) will enter data regarding an individual's patient pay amount obligation in to the Medicaid Management Information

System (MMIS) at the time action is taken on a case either as a result of an application for long-term care services, redetermination of eligibility, or reported change in an individual's situation. These types of occurrences will cause the LDSS to initiate data entry of patient pay into the MMIS.

When more than one provider furnishes services to an enrollee, or the provider to be responsible for collecting the patient pay changes, the DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The support coordinator/case manager should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the LTC provider of his or her responsibility.

For communication of information other than patient pay, the Medicaid LTC Communication Form (DMAS-225) will be used by the support coordinator/case manager to report changes in an individual's situation. This form is available on the DMAS website and is used to provide information on a new address, a different support coordination/case management agency, income, interruption in DD Waivers services for more than 30 days, discharge from all DD Waivers services, or death. The case manager must forward the DMAS-225 to notify DSS when such changes occur. The support coordinator/case manager should document communications.

- If a patient-pay amount is required, the billing indicates the correct amount.

  If there is a patient-pay amount, the CMS-1500, the billing invoice required by DMAS, must indicate that amount.

- Designated DD Waivers services are not used when available from the primary source.

  - The individual's support coordinator/case manager must document before the onset of service delivery that supportive employment services are not available through the Department of Aging and Rehabilitative Services (DARS) or special education funding (as through the Individuals with Disabilities Education Act or IDEA for individuals under 22 years.

  - There must be documentation that it was determined that equipment or supplies provided to an individual under assistive technology services are not available under the *State Plan for Medical Assistance (State Plan)*. This may be documented in the individual's support coordination/case management record by noting the results of reviewing the "Durable Medical Equipment (DME) and Supplies" list available in the DMAS DME and Supplies provider manual for a given item or the results of a telephone inquiry to the DMAS Helpline about the item's availability through the *State Plan*, or both. There must be

documentation for any equipment, supplies, and technology not purchased from a DME provider showing that it was not available from a DME provider. See Chapter IV for additional information.

Annual Level of Care Reviews

Federal regulations under which waiver services are made available mandate that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for that waiver. Reassessments will be conducted at least annually, as determined by the individual's needs, and at any time when a change in the individual's condition indicates the need for reassessment.

Support coordinators/case managers will be required to submit documentation to DBHDS each year to verify that the individual continues to meet eligibility using the VIDES; this documentation will be reviewed by DBHDS staff.

If it is found that an individual no longer meets the level of care, the support coordinator/case manager will inform all providers and services will be terminated in accordance with the procedures detailed in Chapter IV of this manual. DMAS can require repayment of overpaid money if agencies continue to serve individuals who do not meet the level of care for which they are authorized without notifying DBHDS of the change in level of care and the need for discontinuation of services.

REQUIRED DOCUMENTATION

Documentation will be maintained in accordance with applicable statutes and policies. Waiver services that fail to meet DMAS criteria set forth in this manual are not reimbursable. Reimbursement is not permitted in the following situations (not an all-inclusive list):

- Service authorization not obtained and/or not available at DMAS' request;
- Request for service authorization not submitted by the provider;
- Patient pay requirement for the individual, but not indicated on CMS-1500 and paid by DMAS;
- The provider does not meet the qualification criteria;
- The provider staff's personnel files fail to verify that the minimum qualifications outlined in Chapter II are met;
- The individual resides in a nursing facility (NF), an ICF/IID, or a hospital; or
- Duplicate hours or units are billed.

Business and Professional Records

Providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the business. An example of documents in this area is human resources documentation. These policies apply even if the provider discontinues operation. DMAS will be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee will be within the Commonwealth of Virginia.

Individual Records

- The CSB/BHA/provider will maintain for each DD waivers individual the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:
    - The comprehensive assessment and Individual Support Plans;
    - All Plans of Support from every provider;
    - All supporting documentation related to any change in the Individual Support Plan; and
    - All related communication with the providers, individual, consultants, DBHDS, DMAS, DSS, DARS, or other related parties.
- The service providers must maintain the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:
    - All assessments, reassessments, and Plans for Supports;
    - All attendance logs, if applicable, documenting the date services were rendered and the length of time (# of units) and type of services;
    - Appropriate data, progress notes, or support logs reflecting the individual's status and, as appropriate, progress or lack of progress toward the desired outcomes on the Plan for Supports; and
    - Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

- The provider must recognize the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. The individual's written consent is required for the release of information not authorized by law. All information pertaining to an individual must be included in the individual's record.

- Records of individuals receiving waiver services must be retained for six years from the date of service and not less than six years after the date of discharge. The provider must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. If the individual is under 18 years of age, his or her medical records must be retained not less than six years after the individual turns 18.

- All provider contacts with the individual, family members, health professionals, the preauthorization contractor, DMAS, etc. are filed in the individual's records promptly.

- All waiver services record entries and other documentation must be signed with the first initial and last name of the author and dated (month, day, and year). If checklists or similar data collection forms are "initialed," the provider must ensure that there is a current and accurate "crosswalk" of the authors' initials to the names in the record.

- Correction fluid or other forms of deleting information must not be used to make corrections to the individual's record. When an error is made during documentation, a single line must be drawn through the erroneous information; the revision must be initialed by the person making the revision. If an error in a note is corrected at a later time, the person must draw a single line through the error and initial and date the error.

- The individual must be referenced on each page of the record by his or her full name or Medicaid number.

- Documentation must be legible.

COMPLIANCE REVIEWS

DMAS staff or a DMAS-designated contractor routinely conduct reviews to ensure that the services provided to Medicaid individuals are medically necessary, are appropriate, and are provided by a qualified provider. Medically necessary services are those services that are covered under the State Plan or home and community-based waiver and that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the individual's functioning. Providers and individuals receiving services are identified for review by systems-generated exception reporting using various sampling methodologies or by referrals and complaints from

agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, DMAS staff or a DMAS contractor review all cases using available resources, including appropriate consultants, and make on-site reviews or perform desk audits of medical and other individual and provider records as necessary.

DMAS or a DMAS-designated contractor will review a sample of paid claims for the audit period. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Decisions identified in the written report may be appealed by the CSB/BHA or provider. The procedures for submitting an appeal are specified in the cover letter that accompanies the report and must be submitted within 30 days of receipt of the letter.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or as a result of any of the above concerns, Medicaid may restrict or terminate the provider's participation in the Program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
202 N. 9th Street
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations about fraud or abuse by individuals. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the United States Code and Virginia Administrative Code, DMAS will sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Email: RecipientFraud@dmas.virginia.gov
Fax: (804) 371-0881

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity within the Department of Medical Assistance Services. Referred individuals will be reviewed by staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, Program Integrity staff may educate individuals on the appropriate use of medical services, including emergency room services.

Referrals may be made by telephone, fax, or in writing. Written referrals should be mailed to:

Department of Medical Assistance Services
Division of Program Integrity
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 452-5472
Fax: (804) 371-8891
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the quality management problems, as well as the provider name and telephone number. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals.

Electronic Notification of Appeal Rights

When an individual applies for services available under DD waivers the support coordinator/case manager will provide the individual with information about the right to appeal. When initial DD Waivers services are authorized or whenever services for an individual already receiving DD waivers services are increased, decreased, denied or terminated, a notification letter will automatically be generated through the VAMMIS and sent to the provider and individual. The individual's letter indicates the approved, decreased, terminated or denied services and limits and includes the right to appeal if services have been terminated, suspended, reduced, or denied.

Support Coordinator/Case Manager/Provider Responsibilities in Notification of Appeal Rights

In the cases below, because a notification letter is not generated by VAMMIS or because the action will occur prior to VAMMIS electronic notification, the support coordinator/case manager is responsible for notifying the individual in writing of the following actions and the right to appeal these actions:

- An individual's request for a Medicaid-covered service (such as DD waivers, ICF/IID, or TCM) is denied or offered at a decreased level. This does not mean that a particular

provider cannot provide the service, it means that a particular service is determined by the CSB/BHA not to be needed for a particular individual;

- A request for an increase in hours or units or a request for additional services is denied by the CSB/BHA;
- When the CSB/BHA is requesting a decrease or termination of services and 10 business days advance notice is required (as described below);
- TCM services are terminated;
- Individual meets DD waivers' criteria, but is not enrolled in one of the DD waivers, and his or her name is placed on the waiting list;
- Individual is suspended from any service (see Chapter IV for exceptions); and
- Individual's name is moved from the priority one to priority two or three category or from priority two to priority three category of the waiting list or removed from the wait list.

The contents of the notification letter must include:

- What action the support coordinator/case manager or provider intends to take;
- The reason(s) for the intended action;
- The specific regulations that support, or the change in federal or state law that requires the action;
- An explanation of the individual's right to request a hearing;
- The right to request an expedited evidentiary hearing
- An explanation of the circumstances under which the services are continued if a hearing is requested;
- An explanation of the requirement for the individual to reimburse DMAS if the support coordinator's/case manager's/provider's action is upheld, if the individual continued to receive a Medicaid covered service;
- The effective date of the action; and
- The right to representation.

Advance Notification

Unless otherwise specified, written notification must be mailed by the support coordinator/case manager to the individual or authorized representative/guardian at least 10 business days prior to the date of action when a provider reduces or terminates one or all Medicaid-covered service(s).

Exceptions to the 10 Business Day Advance Notice Requirement
Written notice is required in the following cases, but advance notice is not. These include:

- When the support coordinator/case manager has factual information confirming the death of an individual;
    - When an individual or guardian provides a written request indicating that:
- He or she no longer wishes services; OR
    - He or she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
- The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF/IID, NF, or rehabilitation hospital, or has been incarcerated;
- Individual loses financial eligibility for Medicaid;
- The individual's whereabouts are unknown, and he or she cannot be located for the provision of services;
- The CSB/BHA establishes the fact that the individual has been accepted for Medicaid services by another state, Territory, or Commonwealth;
- The individual's physician prescribes a change in the level of care;
- The health and safety of the individual or others are endangered (if appropriate, the support coordinator/case manager or provider must immediately notify the local DARS Adult Protective Services or DSS Child Protective Services, as well as DBHDS Offices of Human Rights and Licensing, as required); or
- When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid covered service is denied or not acted upon promptly (90 days or 45 days respectively) for any reason.

All notification letters generated by the CSB/BHA must be filed in the support coordination/case management record.

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to an individual, the provider will give the individual or family/caregiver and support coordinator/case manager 10 days advance written notice for services provided in non-residential settings. The letter will provide the reasons the provider is discontinuing services and the effective date. The individual is not eligible for appeal rights in this situation and may pursue obtaining services from another provider.

In an emergency situation in which the health and safety of the individual or provider personnel is endangered, the 10 business day advance written notice notification period will not be required, however, the case manager must be notified prior to discontinuing services.

In a provider owned or operated residential setting the provider must follow the terms of the lease/residency agreement when terminating services and/or attempting to evict an individual from the residence. Individuals receiving Medicaid HCBS who reside and receive services in a provider owned or controlled residential setting will have the same or comparable protections related to evictions as individuals not receiving Medicaid HCBS.